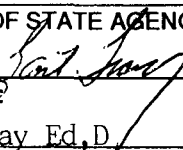



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: <u>0 1 — 0 1 4</u>	2. STATE: Montana
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 04/01/01	
5. TYPE OF PLAN MATERIAL (<i>Check One</i>): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 1902(a)(10)(E) of the Social Security Act Section 4501(b) of OBRA 90		7. FEDERAL BUDGET IMPACT: a. FFY _____ \$ <u>0</u> b. FFY _____ \$ <u>0</u>	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Text pages 20 ⁶ & 29 Attachment 3.1A page 2 Attachment 3.1B page 2a		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Text pages 20 ⁶ & 29 Attachment 3.1A page 2 Attachment 3.1B page 2a	
10. SUBJECT OF AMENDMENT: 4 pages that were inadvertently not updated in May 1993.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Single State Agency Director <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Department of Public Health & Human Services Gail Gray Director Attn: Jean Robertson PO Box 202951 Helena MT 59620-2951	
13. TYPED NAME: Gail Gray Ed.D.			
14. TITLE: Director			
15. DATE SUBMITTED: 06/28/01			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: June 29, 2001		18. DATE APPROVED: 8/2/01	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 4/1/01		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Spencer K. Ericson		22. TITLE: Acting Associate Regional Administrator	
23. REMARKS: POSTMARK: June 28, 2001			

MAY 1993

20b

State: Montana

Citation

3.1(a)(2) Amount, Duration, and Scope of Services:
Medically Needy (Continued)

1902(e)(9) of
Act

- (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23)
and 1929 of the Act

- (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

TN No. TN 01-014

Supersedes

TN No. 93-14

Approval Date 8/2/2001

Effective Date 4/1/01

Revision: HCFA-PM-93-5 (MB)

MAY 1993

State: MONTANA

Citation3.2 Coordination of Medicaid with Medicare and Other Insurance(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and
1905(p)(1) of the Act(i) Qualified Medicare Beneficiary
(QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

X Part A X Part B

— The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

TN No. 01-014

Supersedes

TN No. 93-16

Approval Date 8/2/2001

Effective Date 04/01/01

State/Territory: Montana

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
Provided: ☐ No limitations ☒ With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of child-bearing age.
Provided: ☐ No limitations ☒ With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
Provided: ☐ No limitations ☒ With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
Provided: ☐ No limitations ☒ With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.
Provided: ☐ No limitations ☒ With limitations*

• Description provided on attachment.

TN No. 01-014

Supersedes

TN No. 93-14

Approval Date 8/2/2001

Effective Date 04/01/01

Revision: HCFA-PM-93-5 (MB)
MAY 1993

ATTACHMENT 3.1-B
Page 2a
OMB NO:

State/Territory: MONTANA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY
GROUP(s): All medically needy

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: No limitations X With limitations:

*Description provided on attachment.

TN No. 01-014

Supersedes

TN No. 93-14

Approval Date 8/2/2001

Effective Date 04/01/01